BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: CHRISTOPHER N. Claimant, vs. CENTRAL VALLEY REGIONAL CENTER, Service Agency.	OAH No. 2005050131

DECISION

Administrative Law Judge Robert Walker, State of California, Office of Administrative Hearings, heard this matter in Visalia, California, on March 20, 2006.

Amy Westling, Client Appeals Specialist, represented Central Valley Regional Center.

Darryl Prince, MFTI, Supervising Social Worker III, County of Tulare Child Welfare Services, represented the claimant, Christopher N.

SUMMARY AND ISSUES

Claimant is a regional center consumer.

Regional center reassessed claimant and concluded that the original determination of eligibility was clearly erroneous. Regional center issued a notice of proposed action regarding its intention to end claimant's status as a regional center consumer. Claimant appealed.

Is claimant eligible for regional center services? That is the ultimate issue.

Claimant contends that he comes within the, so-called, fifth category of eligibility. That is, he contends that he has a disabling condition that is closely related to mental retardation or requires treatment similar to that required for individuals with mental retardation.[1] The qualifying conditions are discrete. One can qualify for services if he or she has a disabling condition that is closely related to mental retardation. And one can qualify if he or she has a disabling condition that requires treatment similar to that required for individuals with mental retardation.

Intermediate issues include the following:

1. Does claimant have a disabling condition? (There is no dispute about the fact that he does.)

2. Did claimant's disability originate before he attained age 18? (Claimant is 16 years old.)

3. Can claimant's disability be expected to continue indefinitely?

4. Does claimant's disability constitute a substantial disability for him?

5. Is claimant's disabling condition one that is closely related to mental retardation?

6. Is claimant's disabling condition one that requires treatment similar to that required for individuals with mental retardation?

7. Is claimant's condition solely physical in nature?

8. Is claimant's condition solely a psychiatric disorder?

9. Is claimant's condition solely a learning disability?[2]

FACTUAL FINDINGS

BACKGROUND

1. Claimant, Christopher N., was born on January 13, 1990. He is 16 years old. He has had cystic fibrosis since he was an infant. He has complicated medical needs. It is

[1] The, so-called, fifth category is found in Welfare and Institutions Code section 4512, subdivision (a).

[2] The first seven of these issues are derived from Welfare and Institutions Code section 4512, subdivision (a). Issues numbers eight and nine are derived from the California Code of Regulations, title 17, section 54000, subdivision (c).

expected that his limited breathing will have a progressively greater effect on his brain function. He has also been diagnosed with attention deficit / hyperactivity disorder (ADHD). Claimant lives with a foster family.

THE OPINIONS OF EXPERTS REGARDING CLAIMANT'S CONDITION

2. In the year 2000, regional center was considering claimant's application for regional center services. Regional center asked Howard J. Glidden, Ph.D., to do a neuropsychological evaluation. Dr. Glidden is a developmental neuropsychologist. On May 11, 2000, he examined claimant and wrote a report. As part of his examination, he administered a number of tests.

3. One of the tests Dr. Glidden administered was the Wechsler Intelligence Scale for Children – III (WISC III), a standard IQ test. Claimant's score on the verbal scale was 97. His score on the performance scale was 110. That produced a full-scale IQ of 103, which is within the average range of intellectual functioning. Dr. Glidden, however wrote that claimant's subtest scores ranged from average to superior and that the variation was so great that the full-scale IQ of 103 is not indicative of claimant's intellectual potential.

4. In defining the term "general intellectual functioning," The American Psychiatric Association's Diagnostic and Statistical Manual, fourth edition, Text Revision, (DSM IV TR) addresses the circumstance in which there is a significant discrepancy – or scatter – in scores. The DSM IV TR says that when there is significant scatter the mathematically derived IQ may not accurately reflect the person's abilities and may be misleading. The DSM IV TR says:

> When there is significant scatter in the subtest scores, the profile of strengths and weaknesses, rather than the mathematically derived full scale IQ, will more accurately reflect the person's learning abilities. When there is a marked discrepancy across verbal and performance scores, averaging to obtain a full-scale IQ score can be misleading.[3]

5. After analyzing claimant's various subtest scores, Dr. Glidden concluded that "Christopher's Full Scale IQ [of 103] is felt to be somewhat of an understatement of his true level of cognitive potential."

6. A regional center eligibility assessment team found that claimant was eligible for regional center services. An eligibility team case note dated July 19, 2000, says, in part, "it was agreed to carry his case as a "compassionate" . . . [other condition similar to mental retardation case] secondary to unspecified condition of the brain due to a disturbance of sensation." A July 19, 2000, entry in a diagnostic sheet says that claimant is diagnosed as

[3] DSM IV TR, p. 42.

having "OCMR" (other condition similar to mental retardation.) That entry, however, was not signed by anyone qualified to make the diagnosis.

7. Kathy Sullivan, Ph.D., a licensed psychologist, did a psychological evaluation of claimant. No date was found in Dr. Sullivan's report, but she wrote that claimant was 12 years old. Thus, the evaluation must have been in the year 2002. Claimant was referred to Dr. Sullivan for psychological treatment because he was having numerous emotional and behavioral problems in the foster home in which he was residing. After Dr. Sullivan reviewed Dr. Glidden's evaluation, Dr. Sullivan recommended that claimant be given a battery of projective tests to help to clarify the nature of his psychological problems. Dr. Sullivan reviewed medical, school, and psychological reports. She administered a number of tests. Dr. Sullivan diagnosed depressive disorder, anxiety disorder, and attention deficit / hyperactivity disorder. And she noted the diagnosis of cystic fibrosis. In her summary and recommendations, Dr. Sullivan wrote that claimant's "capacity to produce human movements indicates good intellect, capacity for fantasy and creativity and the capacity for other people to be important to him ideationally and intellectually." She recommended psychotherapeutic services. There is nothing in her report that suggests that claimant is developmentally disabled.

8. In March of 2003, Ronda Schmidt, M.A., a resource specialist for Clovis Unified School District, did a school psychologist evaluation. Ms. Schmidt administered the Woodcock-Johnson Test of Cognitive Abilities III. The results placed claimant's general intellectual abilities in the high average range. The test did not show any significant weakness that would reflect a learning disability or cognitive deficit.

9. Edwyn W. Ortiz-Nance, MAOB, PsyD, a clinical psychologist, evaluated claimant in May and July of 2005. Dr. Ortiz-Nance administered a number of tests and concluded that claimant is of average to above average intelligence.

10. On September 6, 2005, Dr. Glidden reevaluated claimant. He administered a number of tests, including the Wechsler Intelligence Scale for Children-IV. Claimant obtained a full scale score of 102, which corresponds to the average range of intellectual functioning. When Dr. Glidden eliminated the subtest scores for the subtests that have time constraints, he calculated claimant's general ability index as 115, which suggests that claimant's IQ is higher than 102. This recalculation is appropriate for someone with cystic fibrosis. Dr. Glidden did not diagnose any developmental disability.

TESTIMONY OF SHARON CELAYA

11. Sharon Celaya and her husband are claimant's current foster parents. They both attended the hearing, and Ms. Celaya testified. It was clear that she loves claimant and is eager for him to have the best things life can offer. Ms. Celaya testified that she had cared for foster children who were diagnosed as mentally retarded and that claimant was like them in many ways. The following is a paraphrased summary of her testimony in that regard: She

said that claimant does not always get himself clean. He does not want to eat. He wears the same undergarments and socks for days unless someone asks him to change. He needs to be reminded to brush his teeth, take his medications, and do other simple tasks. He is late for school. He must be reminded to do his chores.

12. On cross examination, Ms. Celaya testified that she had cared for foster children who had been diagnosed with ADHD and that claimant was like them in many ways, also.

WHAT IS MENTAL RETARDATION?

13. In determining whether claimant has a disabling condition that is closely related to mental retardation or that requires treatment similar to that required for individuals with mental retardation, it is helpful to know something about mental retardation. The DSM IV TR identifies three criteria – one "essential" criterion and two other criteria -- used in diagnosing mental retardation. The "essential" criterion is "significantly subaverage general intellectual functioning." A second criterion is that the subaverage general intellectual functioning must be "accompanied by significant limitations in adaptive functioning . . . ." And the third and final criterion is that "the onset must occur before age 18 years."[4]

GENERAL INTELLECTUAL FUNCTIONING

14. The DSM IV TR provides that:

> General intellectual functioning is defined by the intelligence quotient (IQ or IQ-equivalent) obtained by assessment with one or more of the standardized, individually administered intelligence tests (e.g., Wechsler Intelligence Scales for Children-Revised, Stanford-Binet, Kaufmann Assessment Battery for Children). Significantly subaverage intellectual functioning is defined as an IQ of about 70 or below (approximately 2 standard deviations below the mean). It should be noted that there is a measurement error of approximately 5 points in assessing IQ, although this may vary from instrument to instrument (e.g., a Wechsler IQ of 70 is considered to represent a range of 65-75). Thus it is possible to diagnose mental retardation in individuals with IQs between 70 and 75 who exhibit significant deficits in adaptive behavior . . . . When there is significant scatter in the subtest scores, the profile of strengths and weaknesses, rather than the mathematically derived full scale IQ, will more accurately reflect the person's learning abilities. When there is a marked discrepancy across

[4] DSM IV TR, p. 41.

> verbal and performance scores, averaging to obtain a full-scale IQ score can be misleading.[5]

15. The DSM IV TR also provides for distinguishing among levels of intellectual impairment depending on the degree of severity of a party's mental retardation. The levels are as follows:

> Mild … IQ … 50-55 to approximately 70
> Moderate … IQ … 35-14 to 50-55
> Severe … IQ … 20-25 to 35-40
> Profound … IQ … below 20 or 25[6]

16. According to the DSM IV TR, people with mild mental retardation:

> typically develop social and communication skills during the preschool years (ages 0-5 years), have minimal impairment in sensorimotor areas, and often are not distinguishable from children without Mental Retardation until a later age. By their late teens, they can acquire academic skills up to approximately the sixth grade level.[7]

17. A person with an IQ between 71 and 84, if not mentally retarded, is considered to be of borderline intellectual functioning. The DSM IV TR provides:

> Borderline Intellectual functioning . . . describes an IQ range that is higher than that for Mental Retardation (generally 71 – 84). As discussed earlier, an IQ score may involve a measurement error of approximately 5 points, depending on the testing instrument. Thus, it is possible to diagnose Mental Retardation in individuals with IQ scores between 71 and 75 if they have significant deficits in adaptive behavior that meet the criteria for Mental Retardation. Differentiating Mild Mental Retardation from Borderline Intellectual Functioning requires careful consideration of all available information.[8]

CLAIMANT'S LEVEL OF COGNITIVE FUNCTIONING

[5] *Id*. at p. 41 - 42.

[6] *Id*. at p. 42

[7] *Id*. at p. 43.

[8] *Id.* at p. 48.

18. What is the level of claimant's ability to acquire knowledge and make judgments? Does claimant's condition involve something that resembles the essential criterion for diagnosing mental retardation? That is, does it involve something that resembles significantly subaverage general intellectual functioning? The evidence is overwhelming that claimant is of average or high average intelligence.

19. It is found that, because of his level of intellectual functioning, he does not have a disabling condition that is closely related to mental retardation.

ADAPTIVE FUNCTIONING

20. The DSM IV TR criterion regarding limitations in adaptive functioning concerns limitations "in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, work, leisure, health, and safety."[9]

> Impairments in adaptive functioning rather than low IQ are usually the presenting symptoms in individuals with Mental Retardation. Adaptive functioning refers to how effectively individuals cope with common life demands and how well they meet the standards of personal independence expected of someone in their particular age group, sociocultural background, and community setting. *Adaptive functioning may be influenced by* various factors, including education, motivation, personality characteristics, social and vocational opportunities, and *the mental disorders and general medical conditions that may coexist with Mental Retardation.* Problems in adaptation are more likely to improve with remedial efforts than is the cognitive IQ, which tends to remain a more stable attribute.[10] (Italics added.)

EXPERT OPINION REGARDING CLAIMANT'S ADAPTIVE FUNCTIONING

21. The DSM IV TR recommends that one gather evidence regarding deficits in adaptive functioning from one or more reliable independent sources e.g. teacher evaluation and educational, developmental, and medical history.

> Several scales have also been designed to measure adaptive functioning or behavior (e.g. the Vineland Adaptive Behavior Scales and the American Association on Mental Retardation Adaptive Behavior Scale). These scales generally provide a

[9] *Id.* at p. 41.

[10] *Id*. at p. 42.

> clinical cutoff score that is a composite of performance in a number of adaptive skill domains.[11]

22. The evidence is in conflict as to claimant's adaptive functioning. There is evidence that his adaptive functioning is satisfactory, but there is other evidence that he has deficits.

DOES CLAIMANT HAVE A SUBSTANTIAL DISABILITY AND, IF SO, CAN IT BE EXPECTED TO CONTINUE?

23. The California Code of Regulations defines substantial handicap as follows:

> "Substantial handicap" means a condition which results in major impairment of cognitive and/or social functioning. Moreover, a substantial handicap represents a condition of sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential.[12]
>
> Since an individual's cognitive and/or social functioning are many-faceted, the existence of a major impairment shall be determined through an assessment which shall address aspects of functioning including, but not limited to: (1) Communication skills; (2) Learning; (3) Self-care; (4) Mobility; (5) Self-direction; (6) Capacity for independent living; [and] (7) Economic self-sufficiency.[13]

24. Certainly claimant's cystic fibrosis is a substantial disability that will continue. But it does not cause an impairment of cognitive or social functioning. It is a physiological disability.

WHAT TREATMENT IS REQUIRED FOR INDIVIDUALS WITH MENTAL RETARDATION?

25. The DSM IV TR contains a modest amount of information concerning treatment. In discussing people with mild mental retardation, the DSM IV TR says:

> During their adult years, they usually achieve social and vocational skills adequate for minimum self-support, but may need supervision, guidance, and assistance, especially when

[11] *Ibid.*

[12] Cal. Code Regs., tit. 17, § 54001, subd. (a).

[13] *Id*. at subd. (b).

> under unusual social or economic stress. With appropriate supports, individuals with Mild Mental Retardation can usually live successfully in the community, either independently or in supervised settings.[14]

26. In discussing people with moderate mental retardation, the DSM IV TR says:

> They profit from vocational training and, with moderate supervision, can attend to their personal care. They can also benefit from training in social and occupational skills . . . . They may learn to travel independently in familiar places . . . . In their adult years, the majority are able to perform unskilled or semiskilled work under supervision . . . .[15]

WHAT TREATMENT DOES CLAIMANT'S DISABLING CONDITION REQUIRE?

27. Because of claimant's ADHD, he may need to have information broken down into small parts and he may need information presented at a slower than usual speed. But there was no evidence that he requires those things because of anything having to do with mental retardation.

28. It is found that claimant does not require treatment similar to that required for individuals with mental retardation.

LEGAL CONCLUSIONS

1. The Lanterman Act is an entitlement act. People who are eligible under it are entitled to services and supports.[16]

> The purpose of the statutory scheme is twofold: to prevent or minimize the institutionalization of developmentally disabled persons and their dislocation from family and community [citations] and to enable them to approximate the pattern of everyday living of nondisabled persons of the same age and to lead more independent and productive lives in the community [citations]. [17]

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[14] DSM IV TR, p. 43.

[15] *Ibid.*

[16] *Association for Retarded Citizens v. Department of Developmental Services* (1985) 38 Cal.3d 384.

[17] *Id.* at p. 388.

2. The act is a remedial statute and, as such, must be interpreted broadly.[18]

3. A developmental disability is a "disability which originates before an individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual." The term includes mental retardation, cerebral palsy, epilepsy, autism, and what is commonly referred to as the "fifth category."[19] The fifth category includes "disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation."[20]

4. Thus, individuals whose IQ scores do not fall squarely within the range of mental retardation can be eligible under the fifth category.

5. The regulations implementing the act provide that conditions that are solely psychiatric in nature, solely learning disabilities, or solely physical disabilities are not considered to be developmental disabilities.[21]

6. A substantial handicap is a "condition which results in a major impairment of cognitive and/or social functioning" which requires "interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential."[22] Whether an individual suffers from a substantial disability in cognitive or social functioning depends on his or her functioning in a number of areas, including: communication skills, learning, self-care, mobility, self-direction, capacity for independent living, and economic self-sufficiency.[23] Cognitive functioning has to do with "the ability of an individual to solve problems with insight, to adapt to new situations, to think abstractly, and to profit from experience."[24]

7. By reason of the matters set forth in Findings 1 through 19, it is determined that claimant does not have a disabling condition that is closely related to mental retardation.

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[18] California State Restaurant Association v. Whitlow (1976) 58 Cal.App.3d 340, 347.

[19] Welf. & Inst. Code, § 4512, subd. (a).

[20] *Ibid.*

[21] Cal. Code Regs., tit. 17, § 54000, subd. (c) (1), (2), & (3).

[22] *Id.* at § 54001, subd. (a).

[23] *Id.* at § 54001, subd. (b).

[24] *Id.* at § 54002.

8. By reason of the matters set forth in Findings 1 through 19 and 25 through 28, it is determined that claimant does not have a disabling condition that requires treatment similar to that required for individuals with mental retardation.

9. It is determined that claimant is not eligible for regional center services.

10. It is further determined that, within the terms of the Lanterman Act, the original determination that claimant has a developmental disability was clearly erroneous.[25]

ORDER

The appeal of claimant, Christopher N., from the regional center's notice of proposed action is denied.

DATED: April 21, 2006

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ROBERT WALKER
Administrative Law Judge
Office of Administrative Hearings

NOTICE

This is the final administrative decision; both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within 90 days.

[25] Welf. & Inst. Code, § 4643.5, subd. (b).